PA COUNSELING
CLIENT REGISTRATION

Patient Name: _____ Date of 1st visit: _____

Date of Birth: _____ Gender: [ ] Male [ ] Female Last 4 SS# _____

How did you hear about PA Counseling? _____

Address/Street: _____

City: _____ State: PA Zip: _____

PHONE: Home _____ Cell _____ Can Text? Y N

Email Address: _____

Marital Status: _____ single _____ married _____ widowed _____ divorced _____separated

If married, name of Spouse/Partner:_____

SUPPORTS Emergency Contact: _____

Relationship to Client: _____Phone _____

If patient is a minor or dependent, please complete the following information:

MOTHER's Name: _____

Mother's Phone (&/or email): _____

FATHER's Name: _____

Father's Phone (&/or email): _____

Guardian/Responsible Party:_____Relationship to client:_____

If you have MA Medical assistance, additional information is needed: # times moved in past 90 days? _____

Do you have a diagnosis of psychosis/schizophrenia, bipolar or BPD? **YES NO** IF YES, circle and answer following:

Do you have 1+ years treatment with PCP or psychiatrist? **YES NO** Have you missed 3+ outpatient mental health appointments within past 3 months **YES NO** Do you have a Psychoactive substance use disorder, homeless, on Parole/probation? **YES NO** 3 missed appts within past 6 mths, unwilling to maintain med regimen **YES NO**

Do you live with family or foster? **YES NO** How many times have you **changed address** within 90 days _____

Are you **employed** or in school or in work program to prepare for employment? _____

If not employed or in school, do you do **volunteer** work or attend a social group? _____